Trauma System Advisory Board Appointment Application

This form is for appointment qualification and article information for appointees. Please attach a biography or resume to this form if available.

Personal Information

Name (Please type or print last name, first name and middle initial)
□ Mr. □ Ms.

_____
Name

_____
Legal Residence Street

_____
City State Zip County

Home Phone _____ Business Phone_____

Date of Birth_____ Occupation_____

The following information is voluntary and is utilized for statistical information only. Under State and Federal law, this information may not be used to discriminate against you.

Gender □ Female □ Male Racial/Ethnic Background_____

Education

Educational Institutions Attended Excluding High School:

School Name Location Dates Majors/Degree

_____
_____
_____
_____
_____
_____

Employment

Statute requires some board appointees meet specific employment criteria. List employment beginning with most recent experiences. A resume or additional information is optional.

Employer Location Dates

_____
_____
_____
_____
_____
_____

Are you a(n): □ First Responder □ EMT □ EMT-I □ Paramedic □ Physicians Assistant □ Nurse Practitioner □ Physician □ Other_____

Please Complete Reverse Side of Form

Additional Information

Please list additional information including honors, awards, organizations, associations, boards or commissions you serve(d) on.

_____
_____
_____
_____
_____
_____
_____

Areas of Interest (Limit Two)
□ Out-of-Hospital □ Hospital □ Rehabilitation □ Designation □ Vehicles/Equipment □ Triage/Transport □ Public Information
□ Prevention □ Pediatrics □ Burns □ Training □ Consumer □ Data Collection □ Quality Assurance

IMPORTANT:
Check ✔ all board appointments for which you are applying. If willing to serve on either statewide or regional boards, please indicate by 1 and 2, the order of preference.

_____ Statewide Trauma Advisory Board Member

_____ Statewide Medical Director

_____ Regional Advisory Board Member (Please indicate Region 1, 2, 3 or 4)

_____ Regional Medical Director (Please indicate Region 1, 2 3 or 4)

List references including names, addresses, and phones numbers of a minimum of three individuals unrelated to you.

_____
_____
_____
_____
_____
_____
_____

As a citizen of the United States and a resident of the State of Nebraska, I will accept appointment if selected by the Director of Regulation and Licensure and if appointed, I pledge my best efforts as an appointee.

_____ _____
Name (Please Print) Signature

_____ _____
Address Date

_____
City State Zip

Submit applications to: Sherri Wren, EMS/Trauma Program
P.O. Box 95007, Lincoln, NE 68509-5007
E-mail: sherri.wren@hhss.ne.gov
FAX: (402) 471-0169